



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF PHARMACY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR RETAIL NON-PHARMACY REGISTRATION INSTRUCTION SHEET

When to File

A retail business that is not licensed as a pharmacy may sell **non-controlled prescription drugs designated for veterinary use** in Delaware if:

- The business registers with the Board of Pharmacy ([24 Del. C. §2523 \(6\)](#)), and
- All such sales are authorized by a written order from a licensed veterinarian and the veterinarian's written order includes all information required for a written prescription.

For complete instructions on storage, security, dispensing, labeling, packaging, and recordkeeping, see Section 7.0 of the Board's [Rules and Regulations](#).

Requirements for All Applications

- ☐ Submit completed, signed and notarized [Application for Retail Non-Pharmacy Registration](#).
- ☐ Enclose the non-refundable [processing fee](#) by check or money order made payable to "State of Delaware."
- ☐ Enclose a copy of the plans for the business.
 - Plans must be drawn to scale and should show the area where prescription drugs will be dispensed, storage area, all entryways and security systems.
 - Plans must also show the type of alarm system installed and the name, address, and phone of the provider.
- ☐ Enclose a copy of the [business license](#) from the Delaware Division of Revenue.
- ☐ Enclose a separate sheet showing the information at right for *each* owner, corporate officer, and employee listed on the application.
 - All persons who will dispense prescription drugs must be at least 21 years old.
 - Name
 - Data of Birth
 - Social Security Number
 - Mailing Address
- ☐ Each owner, corporate officer and employee listed on the application must also complete a *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks.
- ☐ Submit a sample label that meets the requirements of Delaware law at [24 Del. C. §2522](#) and all other applicable federal and state regulations. The label must include:
 - Prescription number
 - Date prescription is dispensed
 - Patient's full name (e.g., animal name) and animal owner name
 - Brand or established name and strength of the drug to the extent that it can be measured
 - Veterinarian's directions as found on the prescription
 - Veterinarian's name
 - Name and address of the dispensing non-pharmacy retail outlet

Inspection Requirement

In addition to meeting all the requirements above, the dispensing area of the business must be inspected before opening. A representative of the business **must notify the Board office** when the area is ready for inspection. When the business passes the final inspection, the Board office will issue the license.



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APPLICATION FOR RETAIL NON-PHARMACY REGISTRATION

TYPE OF APPLICATION

1. Select the items that describe the type of application:

- ☐ Initial Application –
☐ This business has never held a Delaware Retail Non-Pharmacy license.
☐ This business previously held Delaware Retail Non-Pharmacy license number **A** ____ - ____ that has lapsed and is no longer renewable.
- ☐ Application Due to Change of Ownership – Retail Non-Pharmacy license number **A** ____ - ____
- ☐ Application Due to Relocation – Retail Non-Pharmacy license number **A** ____ - ____

LOCATION AND CONTACT INFORMATION

2. Business Name: _____
Enter name as it appears on business license.

3. Name of Proprietor Company (if different): _____

Enclose a copy of the [business license](#) from the Delaware Division of Revenue.

4. Enter all other trade or business names you use (or have used) such as “doing business as” or “formerly known as” names: _____

5. **Location Address:** _____
Street (No PO Boxes) *Note: If you are reporting relocation, this is the new location.*

City State Zip

6. Location Phone: _____ Fax: _____

7. **Mailing Address** (if different from physical location): _____

City State Zip

8. Enter the name of the person who should be contacted for information about this application. He/she may be a representative in the corporate district, an owner or manager. An *Application Receipt* and any other correspondence about this application will be sent to the email address you enter here.

Contact Name: _____ Email: _____

☐ Owner ☐ Manager ☐ Other

OWNERSHIP INFORMATION

9. Type of Business Owner (check one):

- ☐ Sole Proprietor – Continue with Question 10.
☐ Individual with federal employee identification number – Continue with Question 10.
☐ Partnership – **Skip to** Question 11.
☐ Corporation – Enter date of corporate charter: _____ **Skip to** Question 11.

10. Enter the following information about the owner and then skip to Question 12.

Full Name: _____

Date of Birth: _____ Social Security Number: _____

Mailing Address: _____

City State Zip

This person must complete a *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks.

11. If a partnership, list ***all active partners***. If a corporation, list ***all principal officers***.

FULL NAME	TITLE

Enclose a separate sheet listing name, date of birth, Social Security Number and mailing address for each person listed above. Each person listed must also complete a *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks.

12. Do you understand that the Board must be notified within ten days of a change of ownership? Yes ☐ No ☐

INFORMATION ABOUT EMPLOYEES DISPENSING PRESCRIPTION DRUGS

13. Enter this information about of ***all*** employees who will dispense prescription drugs at this business. (If you need more room, attach a separate sheet.)

FULL NAME	BIRTH DATE (month/day/year)

Enclose a separate sheet listing name, date of birth, Social Security Number and mailing address for each person listed above. Each person listed must also complete a *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks.

14. Do you agree to report any change in the employees listed above ***in writing*** within ten days of the change?
Yes ☐ No ☐

INFORMATION ABOUT BUSINESS PREMISES AND OPERATION

15. Business Operating Hours: Weekdays _____ A.M. to _____ PM
 Saturday _____ A.M. to _____ PM
 Sunday _____ A.M. to _____ PM
 Holidays _____ A.M. to _____ PM

16. Will all prescription medications be stored at the location address above? Yes ☐ No ☐
17. The area in which drugs requiring storage a room temperature are stored must be accurately monitored using control devices to maintain room temperature between 59° and 86° Fahrenheit. Does the business have sufficient environmental control (i.e., lighting, ventilation, heating, and cooling) to maintain the integrity of drugs and devices? Yes ☐ No ☐
18. Refrigerators and freezers (where required) where drugs requiring refrigeration are stored must be maintained at the USP/NF range: Refrigerator – 36 ° to 46 ° Fahrenheit; Freezer – minus 4 ° to plus 14 ° Fahrenheit. Does the business have suitable refrigeration with monitoring device? Yes ☐ No ☐
19. When dispensed, prescription medications must be labeled in accordance with the requirements of Delaware law at [24 Del. C. §2522](#) and all other applicable federal and state regulations. Do you understand these requirements and certify that all persons who dispense medications at this business will adhere to them? Yes ☐ No ☐
- Submit a sample label that meets the requirements of Delaware law at [24 Del. C. §2522](#) and all other applicable federal and state regulations.**
20. Prescription drugs must be secured in a manner to prohibit access by unauthorized person and self-service display of prescription veterinary drugs is prohibited. Describe what provisions have been made for the security of prescription drugs, including during any periods of time when no one is available to dispense: _____
- _____
- _____
21. Does the business have an alarm system installed? Yes ☐ No ☐
- Enclose a copy of the plans, drawn to sale, for the business showing the area where prescription drugs will be dispensed, storage area, all entryways and security systems. Include type of alarm system installed and the name, address, and phone of the provider.**
22. Section 7.8 of the Board's [Rules and Regulations](#) explains the recordkeeping requirements related to prescription veterinary drugs purchased, stored and dispensed by non-pharmacy retail businesses. Do you certify that you have read the requirements and will comply with them? Yes ☐ No ☐

DISCLOSURES

23. Have any of the owners, corporate officers or employees listed on this application ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense, including any offense for which they have received a pardon, in any jurisdiction? Yes ☐ No ☐
- Each owner, corporate officer and employee listed on the application must complete a *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks, following instructions on the form for submitting fingerprints. The State Bureau of Identification will send the reports directly to the Board office.**
24. Are any of the owners, corporate officers or employees listed on this application presently charged with committing a felony? Yes ☐ No ☐ **If yes, explain in detail on a separate sheet.**
25. Have any of the owners, corporate officers or employees listed on this application ever applied for a pharmacy permit or controlled substances registration in any State and had the application denied? Yes ☐ No ☐ **If yes, explain in detail on a separate sheet.**
26. Has any of the owners, corporate officers or employees listed on this application ever been the subject of any disciplinary action (formal or informal) by any federal or state agency or any hospital credentials committee including, but not limited to, revocation or suspension of a controlled substance registration or is any such action pending? Yes ☐ No ☐ **If yes, explain in detail on a separate sheet and enclose any relevant documents.**

When your application is complete, please allow 4-8 weeks to receive your registration. A complete application is one that includes all required documentation and correct payment. Applications that are not complete within 12 months of filing may be considered abandoned and discarded.

AFFIDAVIT

I hereby swear or affirm under penalty of perjury that all the foregoing information and statements are true and correct to the best of my knowledge and belief. I hereby further agree to abide by the pharmacy laws of the State of Delaware.

Signature: _____ Date: _____

Print Name: _____ Position: _____

State: _____ County: _____

Sworn or affirmed before me a Notary Public this _____ day of _____, 2_____

Notary Public: _____

SEAL

My commission expires on: _____

**APPLICATIONS THAT ARE NOT SIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY
THE REQUIRED FEE WILL BE REJECTED.**

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See [Title 28, CFR 16.34](#) for the procedure to obtain a change, correction or update in the FBI record.

Locations

Kent County – Primary Facility

State Bureau of Identification
Blue Hen Mall & Corporate Center
655 S. Bay Rd. Suite 1B
Dover, DE 19901

Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility

State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility

Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DeIDOT & Troop 4)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.
2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of \$65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. **Personal checks are not accepted in any county.** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a [FD-258 fingerprint form](#) available on the FBI website at www.fbi.gov – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.
2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.
3. **Mail** the *Authorization* form, fingerprint card, and *certified* check or money order (**personal checks are not accepted**) for \$65.00 made payable to “Delaware State Police” to:

**Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430**

**DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.
DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.**

⇒ ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.



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AUTHORIZATION FOR RELEASE OF INFORMATION
CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

- | | | |
|--|--|--|
| <input type="checkbox"/> Adult Entertainment | <input type="checkbox"/> Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT) | <input type="checkbox"/> Physical Therapy/Athletic Trainer |
| <input type="checkbox"/> Charitable Gaming Vendor | <input type="checkbox"/> Nursing (RN, LPN, APRN) | <input type="checkbox"/> Podiatry |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Nursing Home Administrator | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Real Estate Appraiser (includes Appraisal Management Company) |
| <input type="checkbox"/> Funeral | <input type="checkbox"/> Optometry | <input type="checkbox"/> Speech/Hearing |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy) | <input type="checkbox"/> Social Work |
| <input type="checkbox"/> Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM)) | | <input type="checkbox"/> Texas Hold'em Individual |

Print your current full name:

Last Name First Name Middle Initial Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date:** _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

**Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A**

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.